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ABSTRACT

This publication was developed to provide guidelines for persons conducting continuing education programs for community mental health caregivers. (This would include persons primarily involved in the delivery of health, educational, and social welfare services who also are involved in the psychosocial functioning of their clients.) Following a brief introduction and definition of terms, content is presented under the following categories: (1) sanctions of the continuing education endeavor by both the educational provider's and the community caregiver's organizations, (2) methods of needs assessment, (3) setting program objectives, (4) program design, (5) instruction and the learning process, (6) the arrangements and promotion for a continuing education program, (7) program evaluation and accreditation, (8) financing programs, and (9) program administration. (EN)

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PREPARING COMMUNITY CAREGIVERS

CONTINUING EDUCATION IN MENTAL HEALTH

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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FOREWORD

In late 1975 the Mental Health Program of the Southern Regional Education Board (SREB) received a grant (No. 1-T15-MH14098) from the Continuing Education Branch of the National Institute of Mental Health to strengthen continuing education for mental health throughout the 14 states of the SREB region. The project conducted a survey of continuing education activities then underway in the professional schools, professional societies and mental health agencies (both state and community) to learn more of the needs and problems which were being encountered. Responses showed that there were several areas of general concern: funding; needs assessment; evaluation; gaining sanction for continuing education; credentialing; greater clarification of continuing education responsibilities between the professional schools, the professional societies and mental health agencies; continuing education for paraprofessionals; and continuing education for community caregivers.

A major strategy of the project has been to utilize task forces of small groups of knowledgeable persons to explore some of these issues in detail and to prepare guideline publications which might be of use to persons presently responsible for conducting education programs in mental health or for those persons who may be coming into positions where they will be developing such programs.

We are grateful to the members of the task force who helped develop these guidelines for continuing education in mental health for community caregivers and to the National Institute of Mental Health for support of this entire project.

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INTRODUCTION

Until recently there has been little systematic attention to continuing education in mental health. The field has traditionally been led by a handful of major professions (psychiatry, psychology, social work and nursing), each of which offered training and certification with no great concern for future change or development. For the most part, there has been inadequate attention to mental health continuing education for community caregivers, such as teachers, physicians or social workers, to help them with the mental health aspects of their work. The typical attitude too often has been that these caregivers were not sufficiently trained to be expected to work in such a sophisticated area. At most they were expected to be able to recognize and refer disturbed persons to the fully trained mental health professionals for therapy.

However, the past ten years have seen great changes in the technology and concepts of mental health. There are now new treatment methodologies (e.g., new psychotropic medications, behavior modification, reality therapy); new modes of service delivery (e.g., consultation, education and community planning); and new administrative forms (e.g., community mental health centers, alcohol and drug education centers, hot lines). With all of these new developments in the mental health system it has become necessary to establish a range of educational programs to help the staffs of mental health

agencies to keep up-to-date with the new technology and to help them function effectively in the delivery of services.

One of the major concepts inherent in the notion of community mental health is that there is a wide range of community caregivers who can be helped to recognize and better manage many of the mental health aspects of the people they see as their regular clients. This may involve recognizing and referring seriously disturbed or troubled people to mental health centers, psychiatrists or other appropriate resources. More importantly, however, it is expected that the caregivers will be able to manage a considerable portion of their less troubled clients themselves and that they will be better able to deal with the interpersonal aspects of their clients' mental health.

The notion of using individuals who are already involved with people in a range of helping relationships and of giving "consultation and education" to them was expressed as a national policy in the Community Mental Health Centers Amendments of 1974. The concept includes working with community caregivers for prevention and control of mental disability as well as for early case detection and referral of the mentally impaired. In addition to the consultation and education mandated for federally funded community mental health centers, continuing education for community caregivers also is being provided by many other groups and organizations, such as professional schools, community colleges, professional societies, state mental health agencies and proprietary and voluntary groups.

There are a number of variations to the format or structure through which mental health concepts, principles and methods can be provided to community caregivers. Seminars or workshops can be intermittent or one time affairs. Continuing education might also take the form of a year-long training project in weekly sessions for ministers or police. Juvenile judges might meet an hour a day for three months. The principles and recommendations which follow apply to any of these.

DEFINITIONS

For purposes of this report it is desirable to agree upon the definitions of certain terms so that we can "box the compass" for further discussions. Among key terms are:

> Continuing Education -- systematic learning experiences designed to improve, modify or up-date one's knowledge, skills or values in areas of professional or occupational practice.

Although some definitions include the notion of any kind of life-long learning in the concept of continuing education (i.e., learning to play golf, to raise orchids or to appreciate art), in the context of these guidelines the definition is limited to professional or occupational practice.

Some authors would limit the meaning to formally accredited programs sponsored by colleges or universities. The definition here is not so restrictive; it also includes programs sponsored by operating agencies, such as community mental health centers, professional societies, or private and individual use of programmed instruction materials, but not casual reading. The learning experience does not need to be accredited or systematically evaluated to meet this definition although it is desirable that any continuing education program be evaluated.

Mental health -- the field of knowledge and applied technique which is concerned with the mental and emotional health and illness of the population and the social systems which help or hinder persons in their psycho-social functioning.

This includes all areas of mental illness, mental retardation, emotional disturbance, alcohol and drug abuse as well as the prevention of these conditions and promotion of the mental health of the population at large. It is not restricted to what mental health agencies and their staffs do, but extends to any activities of other community agents or agencies which affect the mental health of people. It encompasses at least three major areas of competence:

Clinical knowledge and skills about the causes and diagnoses of various emotional or mental disabilities and the ability to intervene on behalf of individuals or small groups. This is the area of profesional competence which is traditionally offered in pre-professional training and in continuing education. It is a basic and essential aspect of mental health practice, but it is often not sufficient to provide for the efficient delivery of mental health services.

Knowledge and skills for the delivery of mental health services to clients and communities. These service delivery competencies go beyond the basic clinical knowledge of diagnosis and treatment and include skill in prevention, mental health education [illegible]tion, and rehabilitation. They also include such concepts as the use of teams, community process skills, assurance of patient compliance and maintenance of support systems for clients who have been released from acute treatment but still require extensive assistance in order to function in the community.

Knowledge and skills for administration of programs, funds and personnel to deliver mental health services. Most mental health professionals and paraprofessionals soon find themselves involved in administrative or supervisory responsibilities in addition to their clinical and service delivery duties. Very few pre-professional training programs prepare their graduates for any kind of administrative skills. This area is left either to continuing education or to the "school of hard knocks" which comes with experience.

Community Caregivers -- staff persons of community agencies or independent community workers who are primarily involved in the delivery of health, educational and social welfare services, but who are intimately involved in the psycho-social functioning of their clients through their professional or occupational roles.

This definition includes family physicians, clergymen, nurses, welfare workers, teachers, child care workers, judges, police, parole and probation workers, rehabilitation counselors and community health workers. It might also include persons whose work involves providing other client services in which psycho-social functioning is sometimes intimately revealed, such as, beauticians, bartenders and funeral directors.

It should be made clear that caregivers may be staff members of community agencies or organizations or they may be independent practitioners in the community. They may be professionals with high academic degrees (e.g., physicians or social workers) or they may be persons with relatively meager educational background -- sometimes limited to in-service training for such categories of workers as day care personnel or homemaker-home health aides.

RATIONALE FOR USING COMMUNITY CAREGIVERS

There are several reasons why community caregivers should be considered a part of the total system of mental health services. Studies have repeatedly shown that:

> There will never be enough traditionally trained professionals to meet the mental health service needs of the population.
>
> Most people turn first to a community caregiver for help with an emotional problem rather than to a mental health agency or professional.
>
> There is a built-in relationship between clients and caregivers (e.g., between student and teacher, between parishioner and clergyman) which can be used to improve mental health.
>
> The best avenue to early case detection is through those in the society who spot budding emotional problems and who are in a position to intervene at early stages.
>
> Activities to prevent emotional disturbances and maladjustments from occurring are best conducted by those caregivers who already have regular interpersonal contacts with the people. These are programs of primary prevention.

Caregivers are an important and integral part of the network of human services and of the community mental health system. In recent years there has been a considerable increase in the number of continuing education programs directed to helping the community caregiver recognize pathology and to make referrals to mental health agencies or professionals. However, the mental health professional who limits community caregivers to their regular roles is losing an effective tool for primary and secondary prevention (e.g., promoting mental health and detecting and managing minor problems

which could become serious if allowed to develop).

With the growing acceptance of community caregivers as a recognized component of the mental health delivery system, there has been an increased development of continuing education programs which enhance their capabilities in mental health roles. However, there are several problems concerning continuing education programs for caregivers: what format is most effective; how programs can be arranged and funded; how caregivers can be motivated; and how the programs can be evaluated. These guidelines will address some of these issues and make recommendations for implementing continuing education programs for community caregivers.

There is no single pattern for the enhancement of capabilities of community caregivers which can be used as a template for all such programs. Different locations, different agencies and different developmental stages will modify the method or approach which is most appropriate for any given situation. However, it is hoped that mental health centers or other groups or organizations will find these basic concepts helpful in programming continuing education for community caregivers.

DISTINCTION BETWEEN CONSULTATION AND EDUCATION

In view of the charge in the community mental health legislation to conduct consultation and education, it may be useful to make a distinction between the two:

Consultation is the process of providing expert advice and assistance regarding a clinical case, a problem or a situation or a program. It is rather sharply targeted to the problem for which the consultee has sought assistance. There is sometimes overlap between consultation and education -- especially if the consultant structures the process so that it involves education regarding how the consultee may better manage similar problems in the future as well as resolving the immediate problem for which consultation is requested.

Continuing education, on the other hand, is a planned educational program to enhance the knowledge and skills of caregivers regardless of whether they have perceived a specific problem and requested assistance. Obviously, there are problems in assessing the needs for such educational programs and structuring them in such a way that they are helpful to the community caregivers as well as to the mental health professionals who are conducting the program.

In fact, there is a considerable problem in this area because there has often been a tendency for the mental health professionals to design such continuing education programs in terms of "psychiatry" and "mental illness" while caregivers are more concerned with the everyday aspects of the psychosocial functioning of their clients. Caregivers are likely to be interested in such matters as counseling families in grief, managing resistive patients, and motivating discouraged clients rather than in schizophrenia or psychotic depressions. There is a need for a better understanding of what the caregivers want to, and should, know and for the best methods to train them in continuing education programs.

SANCTIONS

A substantial issue in the matter of continuing education for community caregivers is that of sanction of the whole endeavor. This has two dimensions -- a) sanction from the educational provider's organization and b) sanction from the community caregiver's organization.

Perhaps the most common sponsors of continuing education programs for community caregivers are mental health centers. Federally funded centers are charged by law with conducting "consultation and education" and they have on their staffs qualified mental health professionals to carry out these responsibilities. Continuing education for caregivers is also provided by family service agencies, children's agencies, state mental hospitals, veterans' administration hospitals or state mental health agencies. Private mental health practitioners, academic institutions and professional societies also occasionally sponsor continuing education programs for caregivers. As the responsibility of academia for community services becomes more clear, academic institutions often feel a special obligation to provide continuing education for persons in their local communities. This is particularly true of community colleges and technical schools. In addition, some schools of social work, departments of psychiatry and other professional schools sponsor continuing education programs for community caregivers throughout an entire region or state.

SANCTION FROM THE PROVIDER AGENCY

For many mental health professionals who plan to conduct continuing education programs for community caregivers, it is more difficult to obtain approval from their own agency head than to secure support from the administrator of the caregiving agency. The dean of a professional school or the president of a professional society may give low priority to continuing education for community caregivers as compared to that for staff of his own agency or institution. It is useful for the mental health educator to develop skills in interpreting to the mental health center director, the dean of the college or the head of the organization the value of enhancing the capabilities of caregivers in mental health work.

When this is done successfully, a mental health center becomes known as a major staff development resource for other components of the human services network, as well as a specialized center for the diagnosis and treatment of sick or troubled people. Such a reputation may lead to increased community support and financing for the mental health center.

Many of the same advantages may accrue to the college or professional school which sponsors continuing education programs for local caregivers. Most colleges and professional schools are under considerable pressure to render "community services" and continuing education programs of this kind. As in the case of the community mental health centers, academic based continuing education programs enhance the reputation of the college or professional school as a community resource and increase the base of support for the college. In some cases the funds which result from fees or contracts

for continuing education can be used for support of other college activities.

Top Level Clearance is Essential

All requests to provide continuing education programs for community caregivers should be discussed with the administrative head of the mental health agency or organization. This is important since relationships to outside agencies and organizations are a primary responsibility of any top level administrator. Clearance at the top is also a means of keeping the administrator informed of needs and strategies. Because it is the obligation of leadership to elicit community understanding and support for the agency, the leader must know how the agency is relating to other community agencies and to key opinion makers. While the problems of obtaining permission and support to carry out continuing education in those agencies which have a primary orientation to serving the community, such as community mental health centers and community colleges, will not ordinarily be great, it may be difficult to obtain such sanction from professional societies which usually feel an obligation to their own members rather than to the community at large.

SANCTION FROM THE CAREGIVER'S ORGANIZATION

The matter of obtaining sanction from the community caregivers' agency or association is usually not complicated. In many cases an agency, such as a welfare department or a school system, has made the initial inquiry about having a continuing education program on some aspect of mental health for its staff. Sanction is solidified by responding to the inquiry and formalizing the planning and arrangements.

The mental health continuing educator will sometimes encounter a problem in entering a host system and obtaining approval to conduct continuing education if an agency head is resistant to the idea. There are skills which involve learning about the host system and its needs and offering help related to the administrator's perceptions of the system that may facilitate entering systems. There will be occasions when the clinical referrals to a mental health program from a community agency, such as a school or police department, indicate that the staff of the agency need continuing education about certain aspects of their work. Gathering hard data from the clinical records and contacting the agency head to discuss the problem with him could lead to favorable consideration of a continuing education program.

The agency head who seems ambivalent or uncertain can often be convinced when he is shown the advantages to him. The increased capabilities of his staff may bring prestige to his agency so that it receives more community support. Resistance may be based on a lack of understanding of what mental health education is all about or a feeling that to admit to such a need is a sign of weakness.

If an agency staff member contacts the mental health continuing education provider in regard to a program, the matter should be brought to the attention of his or her supervisor and then to the agency head for approval. The hierarchial structure of organizations should be respected. Any resistance at a supervisory level should be dealt with directly, as it is usually not advisable to attempt to secure a change of administrative decision by going to a higher authority.

It is well to remember that even the community caregivers who are in private practice, such as physicians, clergymen and lawyers, have professional organizations, such as medical societies, ministerial associations or bar associations, which provide a major leadership role for this kind of activity. Officials of these bodies should be involved in planning and arranging continuing education programs for their members.

OBTAINING WRITTEN AGREEMENTS ON CONTRACTS

Most relationships with community agencies arranging continuing education programs in mental health will not require a formal written contract. It is a good idea, however, to have the major points written in a memorandum or agreement which provides a basis for understanding and documentation both for the present and the future. A written record is especially desirable in working with professional associations which are likely to have new officers each year. If money is to be exchanged, a written contract will be required. A written agreement which states the goals and expectations of both provider and consumer may also be used for evaluative purposes.

NEEDS ASSESSMENT

There has been a tendency for some mental health continuing educators to plan programs for community caregivers without an adequate assessment of the caregivers' needs. The most useful continuing education programs focus on providing support and direction regarding the everyday emotional and adjustment problems of the clients with whom the caregiver has a built-in relationship.

The fact that caregivers are not primarily in the business of delivering mental health services puts special obligations on the mental health educator to assure that programs are really designed to meet the caregivers' needs. This is vital for recruiting appropriate participants. Except for certain caregivers whose agencies have arranged the program and directed their staffs to attend, most community caregivers are entirely free to decide whether or not they wish to participate in a given continuing education program.

In such a buyer's market any program of continuing education for caregivers should be preceded by some systematic analysis to determine as accurately as possible what the particular group needs to know to be more effective in the mental health aspects of their work. The procedures for doing an analysis of need may range from fairly simple discussions with selected leaders of the group to complex surveys or self assessment examinations. In some cases the mental health educator will have to explain what is

meant by the term "mental health" since many caregivers think this term refers only to major mental illness. The educator will also have to explain what he or she has to offer and help the prospective participants identify ways in which the proposed knowledge and skills could be useful to them in their work. Data from referrals to mental health treatment programs or discussions of clinical cases in which there is mutual interest may provide a springboard for assessing needs.

METHODS OF NEEDS ASSESSMENT

Surveys, questionnaires, and professional observations are useful tools for identifying the needs of caregivers for education to help them give better service to their clients. Brief surveys by mail or phone are often helpful. The percentage of return may not be great, but the information received represents grass roots interest. Such a survey may later motivate participation in programs because the rank and file members realize they have had a part in the program design. The use of a survey presents the possibility that requests may reflect subjects in which the caregivers already have competence or subjects of exotic appeal rather than real problem areas. However, it may be useful to begin a continuing education program on the basis of these requests and then gradually move to matters of greater need as they become apparent in the course of the program. Spontaneous requests from individual caregivers often provide meaningful clues to what may be needed. The mental health educator should be alert to any of these indicators and be ready to respond.

A planning committee of representative caregivers is often employed in needs analysis. These representatives know their problems and those of their colleagues. This strategy is especially useful if the focus of their suggestions is around psycho-social problems in practice and how these might be addressed, rather than on subjects which may be intriguing, but not really relevant to their practice. The committee may also provide names of persons whom they respect as instructors for the programs.

The recommendation of supervisors is appropriate in agencies such as welfare departments, where supervisors are in positions to know the kinds of problems and needs being encountered by their staffs. This technique also provides greater likelihood that staff persons will be released to attend the programs and that there will be follow-up after the experience. This approach presents the possibility that supervisors may blame ignorance in the staff practitioners for problems which are really caused by organizational limitations, such as poor communications, conflicting objectives, or unclear delegation of authority. This must then be dealt with because continuing education for staff is not a remedy for poor administration on the part of supervisors or leaders.

Evaluation responses from previous program participants have some utility in needs assessment. This technique applies only to programs which follow some initial effort, but it can be a very useful method for assessing further needs, once a series of continuing education programs is undertaken. At this point the group is more sophisticated about what the mental health continuing education program might offer them and about their mental health practice needs.

Every evaluation form should include a request for future program suggestions if there is likely to be an on-going series of continuing education offerings.

Assessment of actual performance from clinical case records of the caregivers provides excellent clues as to continuing education needs. This technique is often possible only for regular employees of agencies which keep and review case records. However, it is becoming more liekly with new peer review requirements (i.e., Professional Standards Review Organizations) and with better statistical record keeping in community mental health centers. This method has the advantage that it identifies the everyday problems of the caregivers which represent the real difficulties being experienced by the practitioners. This technique provides a relevancy and a motivation which can be obtained in no other way. It also furnishes an excellent base line against which the effectiveness of the continuing education program can be evaluated.

Inquiries to professional societies can reach groups not accessible through official agencies. Physicians, attorneys, and other professionals who are not associated with an agency usually are affiliated with a professional society. There may be a continuing education committee which can assist in identifying needs of members. The mental health professional can sometimes make a presentation at a professional society meeting to explore how members can more adequately fulfill their mental health roles. Through such an appearance, needs can be determined and programs planned.

SETTING PROGRAM OBJECTIVES

In the field of continuing education attention should be paid to the setting of program objectives in terms which will lend themselves to ultimate evaluation. The participants should have a reasonably clear idea of what they can expect to get out of the program so that they can measure their progress against the stated objectives. In general, it is preferable to set objectives in terms of the behaviors or activities which the learners will carry out in their practices. The aim should be to make their work with clients both more effective and more efficient. This requires attention to all aspects of how the caregivers presently serve their clients and what mental health knowledge can most appropriately be worked into the overall presentations. This usually requires a period of exploration and discussion to determine how the caregivers can best use the mental health information in their individual situations.

In setting program objectives in mental health the continuing educator should avoid the tendency to set the objectives only in terms of the mental health agency's major goals. Community caregivers are not likely to have a major interest in taking responsibilities for the mentally ill and seriously disturbed, but often information about psychosis and neurosis can be included in a continuing education program which is primarily directed to other mental health concerns of the caregivers. Objectives, therefore, would

not relate to increasing knowledge about psychiatric matters, but would have to do with such aspects of this knowledge as pertain to the caregiver's regular work. A continuing mental health education program for community caregivers may not readily lend itself to a statement of measurable behavioral objectives, but objectives should be stated in graphic and specific terms which are clear enough at the outset so that participants can have some base line and yardstick to go by as they enroll in the program.

Objectives should not be too global or long-range. It is preferable to set objectives which deal with a specific problem or purpose which can realistically be accomplished within the time available and under the condition of the particular program or course. Principle points to remember in setting objectives for continuing education programs for community caregivers are to: 1) base them on needs, 2) be specific, and 3) fit objectives to the goals of the caregivers.

PROGRAM DESIGN

Following the overall assessment of needs and setting of objectives for a continuing education program for community caregivers, there is the task of designing the individual programs so that they fit the specific practice requirements of the caregivers. There are several factors to be considered in program design:

> The subject areas should focus on the areas in which caregivers are having practice problems.

Different aspects of the same subjects may be stressed at different times -- sometimes for applied skills, sometimes for new attitudes, and sometimes for help in administering programs in the subject area.

> The learner group can often suggest the format of the programs.

Some professions prefer didactic lectures or panel presentations with questions. Others prefer case studies, videotapes, or experiential simulations. The formats are likely to change as people become more widely experienced with different modes of learning. Provisions should be made for variety and flexibility to conform to new requests and changing sophistication.

> It is important to assure that time and place arrangements are convenient for attendees.

The preferences are often extremely varied. For instance, practicing

physicians may prefer Sunday meetings for their programs, while certain other groups, such as clergymen or salaried agency employees, cannot or will not attend Sunday programs. It is essential to consider the schedules and convenience of the agency and the caregivers in making program arrangements. In the case of school teachers and their principals, arrangements should be made for substitute teachers or the programs should be scheduled outside of classroom hours.

> Frequently caregivers have strong preference for instructors who are either: a) "big names" in their field, b) persons known by the caregivers to be knowledgeable, or c) persons experienced in caregivers' area of work. These preferences for certain instructors should be respected by the program planners.

The selection of instructors is a vital matter. The instructor must be knowledgeable both about mental health concepts and the area of practice of the caregivers. The instructor should also possess the appropriate educational expertise and be sensitive to the needs and reactions of the trainees. Individuals with practice experience in the same field as that of the caregivers often make better instructors than university professors or mental health professionals with no experience in the caregivers' field. The instructor is almost always a model for the trainees, and the kind of model which is to be projected will be a prime determinant in selection of the individual instructors.

The value of selecting individual caregivers to be instructors should not be overlooked. They can be used as small group leaders and as presenters for

some of the sessions. They can certainly present cases from their own practice in a more relevant fashion than most mental health professionals. Having caregivers as instructors helps establish rapport with the other trainees and adds a practical and relevant ingredient.

> Program planners should be aware of the importance of flexibility.

Even with careful assessment of needs, it is necessary for the mental health continuing educator to remain alert to changing or newly emerging needs of the participants as the program proceeds. It is not at all unusual for a sequence to be planned to improve caregivers' knowledge and skills in a subject area (e.g., recognizing and counseling of alcoholics) only to have it soon become apparent that the real problem is one of attitudes. There is no pat technique for assessing these changing needs, but the educator should remain alert to the necessity for revising content and methods to meet new needs as they arise.

> The question is sometimes asked about core curricula which can be used in mental health continuing education for community caregivers.

There are probably no core curricula which can be applied routinely to any and all caregivers, but there are certain themes which are likely to come up in such training programs. The continuing educator should be ready to deal with them when they arise. Among them are:

Interpersonal skills for working effectively in a helping relationship with clients. These items of genuineness, accurate empathy and non-possessive

warmth (as defined by Truax and Carkhuff*) seem to be key elements of any helping relationship and can be taught regardless of the profession or field.

Role relationship problems present another frequent theme for community caregivers. The caregiver's major social role as a policeman, physician or clergyman, often seems to call for the caregiver to be vested in authority, an image which conflicts with the more colleagual and listener role of a mental health counselor. These roles can be blended, but it is often necessary to give specific attention to this conflict and how it might be resolved.

Problems around arranging time for mental health counseling of clients and making fee charges for this kind of work are common to any caregiver group. Physicians, lawyers, clergymen and teachers often feel that long 50-minute therapy hours are necessary in order to add a mental health dimension to their work. They may need to realize that the time they are already devoting to clients can be used therapeutically. Sometimes caregivers in private practice feel that they cannot legitimately charge clients for "just talking" with them. They need help to realize that such a service deserves a fee just as much as any more traditional service.

Knowledge of community resources is a necessary part of the equipment of any caregiver. Sometimes community caregivers try to manage client problems by themselves with no awareness that there are other community resources, such as family counseling centers, day care programs, rehabilitation counselors,

*Carkhuff R. and Truax, C. B. Toward Effective Counseling and Psychotherapy, Aldine, 1967

visiting nurse associations, homemaker services and pastoral counselors, upon whom they can call to help with various aspects of the client's problem. The mental health continuing educator should be prepared to offer information about other community services and how to enlist them on behalf of clients. Techniques of referral and collaboration are essential skills in the practice of most caregivers.

A great deal of the literature of primary prevention in mental health describes the importance of support and consultation to individuals at times of crises in their lives. Virtually all community caregivers see clients in times of everyday life crises and can provide support and consultation at those times. Thus, the matter of crisis management is a common theme in continuing education programs for caregivers. Obviously, the specific nature of the crises encountered by school teachers will vary from those encountered by clergymen or policemen, but many of the principles and techniques are similar.

INSTRUCTION

Instruction in a continuing education program in mental health for community caregivers deserves special attention to assure that it meets the needs and expectations of the consumers. Since the usual pattern of much of basic professional education is the formal lecture, it may be the first method of choice for instruction to professional groups. This is an efficient instructional technique for imparting knowledge, but it has limited usefulness for developing new skills or for modifying values and attitudes. It is, however, advisable to start where the learners feel comfortable and move from there to other experiential learning techniques which can be worked into the the program along the way.

> The maximum learning seems to take place when the learners are actively involved in such learning techniques as group discussions, role playing or simulations.

In addition, the learning of skills and changing of attitudes require actual participating and performance on the part of the learner. For these kinds of learning, experiential exercises, such as real case presentations, simulations, videotape playbacks and mini-labs, are most useful.

> Lectures and panels should be oriented to the needs and problems of caregivers.

Forcefulness and a down-to-earth style are always well received, while

jargon and theoretical abstractions tend to leave caregivers frustrated. Specific information and practical suggestions are greatly appreciated.

The instructors must feel and display confidence in the ability of caregivers to recognize and work effectively with emotional problems of their clients. Instructors must not be disdainful of the caregivers or of their agencies.

> A critical aspect of instruction is the attitudes and values which instructors have about the professions and agencies of the caregivers.
>
> In using caregivers as presenters, it is possible to capitalize on their unique understanding of the needs and problems of their fellow caregivers.

This enables them to expedite the translation of the new knowledge and skills into the language and practice settings of their colleagues. They also frequently either already have or can easily establish a problem solving format which speeds up learning.

> The learning process for community caregivers will be expedited if the focus of the entire program is on problem solving ways to make their practices more effective and efficient.

All of the didactic instruction is then placed in the context of background material relevant to the learners' practice. Their participation in identifying problems is essential because the mental health expert is not always familar with the caregiver's field of activity.

In planning the content of a continuing education program for community caregivers it is well to make no firm assumptions.

This applies to what the learners may already know or the problems they really face. Very often it turns out that the caregivers are functioning with less knowledge or entirely different assumptions than had been presumed. On the other hand, some caregivers may have more knowledge and experience in mental health than had been anticipated. Sometimes they can bring to the group creative ways they have found to deal with mental health issues. The wise instructor thus seeks frequent inputs from learners to validate or dispel previous assumptions.

The question of whether training for community caregivers should be interdisciplinary is often raised.

If the program is requested by an agency to serve all of its staff members, regardless of profession, the programs can probably be scheduled to be interdisciplinary both in respect to the faculty and the participants. This is generally a desirable arrangment whenever it is appropirate. The educational level of the caregivers, the topic to be addressed and the functions of the agency help to determine whether or not an interdisciplinary approach will be valuable. If the continuing education need of the caregivers is to learn how to collaborate with other agencies, it is well to use representatives of these agencies as part of the learning experience.

ARRANGEMENTS AND PROMOTION

The arrangements and promotion for a continuing education program for community caregivers should be carefully planned and carried out. Of necessity there is an element of marketing much the same as in show business -- especially when the program is not obligatory for caregivers who are busy with many other responsibilities which absorb their time and energies. Major factors to be considered in arranging and promoting are:

> A planning committee of caregivers can be very helpful in deciding the time and place of sessions for they know the schedules and concerns of their associates.

A survey may also have provided some suggestions. Frequently it is desirable to provide continuing education programs in mental health at the regular meeting times and places of the trainee groups (i.e., at the staff meeting of the general hospital, at the ministerial association meeting, at the teachers' meeting of the school). It is almost always preferable to take a program to the caregivers rather than to ask them to come to the mental health center, university or other unusual location.

Programs also may be held in local hotels, community colleges, community centers, churches or other public places. It is always important to check and confirm arrangements and to make sure of details concerning all physical properties. The physical and social aspects of the program add to the comfort

of the group, make them more receptive and motivated, and enable participants to become highly involved. Plans should be made for coffee breaks and often for receptions or meals especially if the program is to continue over some period of time. If the participants are going to have to be away from home for more than one day, suitable housing arrangements will have to be made and confirmed.

> The announcements for a continuing education program should be both attractive and specific in the information they provide.

The wording of the title of the program is of great importance in recruiting participants. It should be crisp and appealing so that it clearly identifies the subject and what potential participants can expect to get from the program. Titles which are too abstract or academic in tone are likely to turn off potential registrants. Titles which promise practical "how-to" assistance for practitioners are more apt to have appeal.

Currently, most continuing education programs in mental health use a printed brochure to announce programs. The brochure has all of the essential information about the program -- title and sponsoring organization, program objectives, audience expected, tentative schedule, instructors and their qualifications, time and place, credits to be awarded, fees, arrangements for housing, and directions for finding the meeting place. There is usually a pre-registration application form for participants to fill out and return. All pre-registration should be acknowledged if possible. Certain kinds of continuing education programs are appropriately announced and reported in

newspapers. If often stimulates attendance to have had a brief article about the program appear in the local newspaper a day before the program itself. A report on the program after the event is also newsworthy and aids in maintaining community support.

> The size of the group and the type of program determine how plans are made and carried out.

The above ideas are more appropriate for formally structured continuing education programs. Other types of continuing education for community caregivers might include regular small group meetings of clergy or police over an extended period of time and would require different plans and arrangements. The composition of the caregiver group and the nature of their learning needs determine the format and arrangements for a program. There are endless variations to the patterns through which mental health concepts, principles and methods can be provided to community caregivers but, in all cases, special attention should be given to potential participants' needs and convenience and to assure that there is advance notification of programs.

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EVALUATION AND CREDENTIALING

Every continuing education program should be evaluated in several ways. At the very least there should be opportunity for each of the participants to express his judgment about the educational process -- whether the program was helpful, whether the instructors were satisfactory and whether the arrangements were suitable. These judgments will help in planning future programs. They can be obtained by an evaluation form to be filled out by each participant at the end of each program. This provides evaluation of the process -- not the outcomes -- but it is a valid and important aspect of evaluation.

Along with this, the mental health continuing educator should keep administrative records of the names of the persons in attendance, demographic details about the participants, and records about the subjects and instructors to aid in evaluating the overall continuing education program. This information, considered along with fiscal data about expenses incurred and fees received, can be used for cost accounting of the program.

The evaluation of the learning itself is somewhat more difficult. Techniques which are often used include:

> Paper and pencil tests given before and after continuing education programs to measure changes in opinions or knowledge. However, many caregivers resent such tests. Sometimes the explanation that the results are needed for program planning and overall program evaluation makes them more acceptable, and sometimes the testing procedures can

be cleverly incorporated into the instructional process itself.

Other kinds of before and after tests can be used. Among these are responses to programmed materials, trigger films, videotapes and simulations conducted at the start of the training program and again at the end. These are often more palatable to the caregivers and are easier to incorporate into the learning process so that they do not appear to be "tests" in the usual sense.

If clinical case records have been used to assess the need for the program in the first place (e.g., from peer review programs), it is useful to continue to monitor clinical records of the participants' clients to learn whether their practice behavior has changed. This, of course, is the ideal condition for evaluation, but it is too seldom employed. Sometimes it is possible to evaluate unobtrusive measures of the changes resulting from continuing education (i.e., changed patterns of referrals to the local community mental health center).

It may be possible to call or visit participants at some time following the program to ask what changes they have made in their practices as a result of the programs. Supervisors of salaried caregivers may be able to tell from their observations whether there has been a change in the practices of those who participated in the continuing education program.

If there are sufficient funds, it is often desirable to design a systematic follow-up program of visits to the practitioners in their agency or office settings. This kind of evaluation could cost as much as the original training program, but there are instances when it should be done to be sure that the continuing education is having some real impact on the practitioners' practice behavior.

In these days when many professional societies and licensure boards are requiring evidence of continuing education for continued membership or for relicensure, it is important that continuing education programs be prepared to offer some kind of certificate as a credential for persons who participate. This involves keeping accurate records of attendance which can be referred to and readily assessed years later to verify an individual's participation at a

particular program together with the amount and kind of credit he received.

The two major systems of formal program accreditation for continuing education in mental health are the Category I Continuing Medical Education credits of the American Medical Association for physicians, and Continuing Education Unit credits for other professions.

The AMA system, which is increasingly becoming mandatory by medical societies, medical licensure boards and hospital staffs, requires that a physician have 60 hours of Category I credit among a total of 150 credit hours of continuing medical education every three years. The training programs which award Category I credits must be accredited by the American Medical Association. This system applies only to physicians and the various medical specialties.

The other major system of accreditation is the Continuing Education Unit (CEU) which is recognized generally in the field of higher education for a wide range of professions and technologies. A CEU is awarded for every 10 clock hours of formally structured continuing education by a training program structured to award the CEU. A national Task Force developed the concept of the CEU and has stated specific criteria to be followed before an institution can award these units. There is still need for further clarification of several issues involved in CEUs, but the CEU is rapidly gaining acceptance as the credential for continuing education.

Both the AMA and CEU systems expect the overall training program to be of high quality if it awards certificates to individuals. The accreditation

requires that there be an assessment of needs, that the programs be carefully planned, that there be specific objectives, that an evaluation be made and that records be kept. All of this calls for a considerable amount of administration and structure, but it is becoming increasingly an integral part of continuing education for all of the professions of our society.

With the growth of professional mandates for continuing education, and the increasing demand of agencies that all workers participate in continuing education in order to be eligible for pay raises and promotions, there will probably be an increase in demand from caregiver groups who will need certain kinds of credits. The mental health system should be prepared to provide the kind of caregiver continuing education which help these workers to fill their mental health related roles and to gain the desired credentials.

Certificates and reports which are provided to a caregiver may be of value in meeting some future requirement for licensure or certification. Whatever the circumstances of the experience, a caregiver who takes part in a structured and competently conducted mental health continuing education program should receive tangible evidence of his accomplishment.

FINANCING

Little systematic attention has been given to financing continuing education for community caregivers, even though this is an essential facet in the development of programs. Mental health continuing education programs for caregivers have relied upon various funding methods.

A major source of funding for continuing education of community caregivers has been provided under the Consultation and Education budgets of community mental health centers. The question of financial support for such programs after federal funds for community mental health centers have ended remains to be addressed. This is a justifiable expenditure of public funds, but it will require specific documentation in the budget requests to local county commissioners or state finance officials. The advocacy of caregiver groups who are satisfied customers should be an asset in appealing for public funds.

If the continuing education program is requested by a community agency in order to help its staff to do a more effective job in the mental health aspects of their work, that agency may be able to pay the costs of the instructional programs as a part of the agency's staff development budget. This arrangement usually requires a written contract with specific budget arrangements. Many school systems, social welfare agencies and industries are using such a system.

For private practitioners in the higher income brackets, a common practice is to charge a substantial registration fee to cover the instructional costs of individual programs. This arrangement is satisfactory for practitioners in higher income groups, but it is not feasible to charge high registration fees for persons in low or modest income levels. Even when substantial fees are charged, they seldom cover much more than the instructional costs of the program. The basic cost of the overall administration -- the planning, the arranging, evaluating and record keeping -- still need to be covered. There should be some mechanism for financing these costs.

Another possible source of funds for continuing education programs for caregivers is grants from local merchants, pharmaceutical companies and book publishers. Civic clubs, mental health associations and local service organizations which have an interest in mental health have sometimes provided funds for continuing education programs. It is appropriate to accept grants from companies which do business with the potential participants, but it is also well to have certain specific guidelines for such grants. These might include provisions that there shall be no active sales promotion at the training sessions, that the sponsorship firm shall not have exclusive display rights for exhibits at the meeting, and that acknowledgements will be limited to certain forms. Without such guidelines, the continuing education program may find itself accused of favoritism and commercialism.

Federal grants from the National Institute of Mental Health or other agencies are another source of funds for mental health continuing education for caregivers. One source which has often been overlooked is the U.S. Office

of Education. Since the passage of the Elementary and Secondary Education Act there have been a number of federal laws passed providing special funds for training teachers and ancillary personnel in the schools.

These resources could be used for training teachers in the mental health aspects of their role. Other federal funding sources, such as Title XX of the Social Security Act, may provide monies for continuing education of community caregivers to make them more effective in their mental health roles.

It is possible that other resources might be tapped for funds or facilities which would otherwise cost money. Churches have provided housing and monies for mental health continuing education for clergy and other caregivers. Y.M.C.A.'s, community colleges and other community resources may be amenable to providing space, volunteers, equipment and, sometimes, funds.

Most of these approaches to funding are "soft" money which has a substantial element of uncertainty. While a certain amount of scrambling for funds of this kind is desirable to assure that programs remain relevant, it can be damaging to the overall program to have the very existence of a continuing education program placed in this kind of entrepreneural situation. A basic budget commitment would seem to be essential for a mental health agency or organization which is serious about providing continuing education for community caregivers. Such a basic budget would provide for security and continuity of a staff to do planning, programming and evaluation.

ADMINISTRATION

From the items already discussed it is apparent that there must be effective administration for a successful program of continuing education for community caregivers. Someone must have the time and responsibility for undertaking the assessment of needs, the planning and arranging, the evaluation, the record keeping, and the obtaining of financing and budgeting. In too many agencies and organizations there has been inadequate recognition of these needs and consequently poor definition of administrative responsibility. Overall sanction and support for continuing education of community caregivers must come from top administration, but there must also be an administrative structure assigned to this function.

In an agency such as a community mental health center, the basic responsibility for continuing education of community caregivers should preferably be assigned to a single person. Usually the person who has overall responsibility for coordinating all Consultation and Education activity is placed in this role. Otherwise, what is everyone's responsibility ends up being no one's responsibility. This does not mean that this one person will be the organizer and planner for all continuing education programs. Rather, this person's responsibilities should be to encourage and assist other staff persons of the mental health center to undertake appropriate continuing education programs. This will facilitate and assure a higher quality for

all of the various continuing education programs offered by the mental health center.

For professional schools or societies it would also seem desirable to have a single person assigned to continuing education responsibilities both for staff and for community caregivers. This person could be supported by a committee of other members of the faculty or association. The title might be Coordinator or Chairperson of Continuing Education. This is not only a way in which the organization can provide sanction for continuing education, but it also provides a specific mechanism for carrying out this charge.

There are a few areas in which broad administrative support for continuing education of community caregivers might be developed to enhance and better assist the whole effort. Among them are:

> Inclusion of continuing education for caregivers as a formal objective of state and local mental health programs. This would help provide on-going funding, staffing and technical resources to help in the continuing education work for caregivers in all parts of the state and community.
>
> Establishment of state level programs to accredit and record continuing education credits for individuals so that each individual program does not have to set up and maintain its own record keeping system. This would require agreement of the mental health agencies, the professions and the professional schools.
>
> Conducting of state level and regional workshops to clarify guidelines for various aspects of continuing education for caregivers, to train administrators and instructors of continuing education and to share specialized resources.

Establishment of state and regional newsletters or other mechanisms to exchange information about continuing education programs for caregivers to better coordinate and share resources.

STRATEGIES FOR GAINING AND MAINTAINING ADMINISTRATIVE SUPPORT

Continuing education of community caregivers can take place in a variety of settings under the sponsorship of different agencies.

To assure that the administration develops a commitment and continues support for continuing education programs for caregivers, there needs to be continual demonstration of how continuing education programs help the agency to reach its goal by helping caregivers to deal with situations which would otherwise overburden the facility. The continuing education program director must constantly seek out and feed back to top level agency leaders information demonstrating that continuing education for community caregivers has an impact on agency practices and on the delivery of community services.

A good evaluation effort is convincing to administrators, especially if it is based on hard facts showing changed patterns of referral and follow-up of cases. Evaluations which show results and satisfied customers are a help in maintaining administrative support. Cost analyses which show the economy of providing continuing education for community caregivers will also assist in establishing a priority for continuing education in the total agency program.

SUMMARY

Community caregivers are a significant component of the total mental health system and can be utilized to extend the service potential of traditional mental health services.

Almost every human service worker is a caregiver in the sense that troubled people make use of their regular working relationships to help deal with emotional problems. There are certain categories of individuals, however, who are more apt to be seen by the public as logical sources of help by virtue of their roles (e.g., ministers, teachers, family doctors, public health nurses and policemen). The foregoing suggestions are addressed to persons in mental health agencies, professional schools, and professional societies, who design and implement continuing education programs for these and other community caregivers.

There are certain problems in developing programs which need to be understood and dealt with in evolving systems of continuing education for caregivers. Different levels of competence, varied understanding of community need and inconsistent interpretations of the consultation and education process constitute some of the barriers to developing effective programs.

Factors which play a part in determining the outcome of continuing education endeavors for community caregivers are the matter of sanctions and

funding; the quality of needs assessment; setting of objectives; program design; the quality of instruction; evaluation and credentialing.

Successful continuing education for community caregivers requires attention to all of these components and to the principles of starting where the participants are, planning collaboratively, and maintaining the flexibility to change course when developments indicate a need for change. There are a number of mental health organizations which provide continuing education for community caregivers. These offerings take a variety of forms, ranging from one time help with a specific problem to long-range, on-going programs for staffs and agencies. In all of these it is important to critically analyze the needs, set clear objectives, to target the instructional program clearly to the need, and to secure and maintain administrative support from both the provider system and the caregiver system.

Throughout all the professions, agencies and institutions there will be a growing demand and acceptance of continuing mental health education for community caregivers as a part of the mental health delivery system. Persons who are responsible for developing the programs to meet this demand will do well to develop all components of their programs in a systematic way so that there will be high quality programs to meet the need.

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